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Nos.

In the Supreme Court of the United States

OCTOBER TERM, 1981

METROPOLITAN LIFE INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY, APPELLANT

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEALS FROM THE SUPREME JUDICIAL COURT OF MASSACHUSETTS

APPENDIX TO JURISDICTIONAL STATEMENTS

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APPENDIX A

SUPREME JUDICIAL COURT OF MASSACHUSETTS
SUFFOLK

No. 2542

ATTORNEY GENERAL

v.

THE TRAVELERS INSURANCE COMPANY ET AL.[1]

Argued Dec. 9, 1981

Decided March 24, 1982

Before HENNESSEY, C. J., and WILKINS, LIACOS, NOLAN and O'CONNOR, JJ.

HENNESSEY, Chief Justice.

General Laws c. 175, § 47B, specifies mandatory minimum mental health care benefits for Massachusetts residents, which must be included in any general insurance policy, accident or sickness insurance policy, or employee health care plan, if the policy or plan covers hospital and surgical expenses.[2] The principal question before us is

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[1] Metropolitan Life Insurance Co.

[2] General Laws c. 175, § 47B, inserted by St. 1973, c. 1174, § 2, provides that: "Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which

whether § 47B is preempted by either the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1976, Supp. I 1977, & Supp. II 1978) (ERISA), or the National Labor Relations Act, 29 U.S.C. § 151 et seq. (1976 & Supp. III 1979) (NLRA). In addition, the defendant insurance companies raise issues concerning severability, the effect of § 47B on policies issued before its effective date in 1976, and the applicability of the contract clause of the United States Constitution, art. 1, § 10. We conclude that the provisions of § 47B pertaining to insurance are not preempted, and that they are severable from a provision pertaining to employee benefit plans,

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is promulgated or renewed to any person or group of persons in this commonwealth while this provision is effective shall provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

"(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause 'psychotherapist' shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry."

which the parties have assumed to be preempted. We also conclude that § 47B applies to certain policies issued by the defendants before 1976, and that this application of the statute does not violate the contract clause.

The Attorney General brought this action for declaratory and injunctive relief to enforce § 47B against insurance companies that issue group insurance policies providing medical coverage to Massachusetts employees.[3] The parties stipulated that nearly all of the defendants' group policies covering Massachusetts employees insure welfare benefit plans subject to ERISA. In addition, a number of the policies insure plans mandated by collective bargaining agreements negotiated pursuant to the NLRA.

A Superior Court judge issued a preliminary order requiring the defendants to provide the mental health coverage described in § 47B. After trial, a second judge granted a permanent order to the same effect. We granted the defendants' application for direct appellate review.

1. *Severability.*

Although § 47B applies by its terms to "employees' health and welfare fund[s]," as well as to policies of insurance, the Attorney General has not enforced it against uninsured plans subject to ERISA. The present case involves only insurers, and all parties have assumed that direct enforcement against plans is preempted by ERISA. A threshold question, therefore, is whether the provisions

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[3] The defendants have not included the required benefits in certain policies issued outside Massachusetts that provide coverage for Massachusetts employees, and certain policies issued before January 1, 1976. (These will be discussed later in this opinion.) The parties stipulated that the defendants have included the required benefits in policies issued or renewed in Massachusetts after January 1, 1976, but the defendants reserved the right to challenge § 47B as applied to these policies. Thus the defendants are asserting the invalidity of the statute with respect to all policies of insurance, whether issued before or after January 1, 1976, inside or outside the Commonwealth.

of § 47B requiring the inclusion of mental health care benefits in policies of insurance are severable from the provision pertaining directly to benefit plans. We believe that they are. The insurance requirements "have independent force, thus justifying the inference that the enacting body would have passed one without the other." *DelDuca v. Town Adm'r of Methuen*, 368 Mass. 1, 13, 329 N.E.2d 748 (1975). The judge's findings indicate that many plans purchase insurance, and that § 47B as currently enforced (against insurers only) has brought about significant improvements in mental health care in Massachusetts. The judge also found that there was no credible evidence that partial enforcement of § 47B had caused plans to shift to self-insurance.

In light of our conclusion that the insurance provisions of § 47B are independently enforceable, the following discussion of preemption will be limited to the statute's application to policies of insurance.

2. *Preemption—General Principles.*

By the operation of the supremacy clause of the United States Constitution, art. 6, Federal law preempts conflicting State law. *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 210-211, 6 L.Ed. 23 (1824). The conflict may be direct, in the sense that State regulation contradicts Federal regulation, see *McDermott v. State*, 228 U.S. 115, 132-134, 33 S.Ct. 431, 435-436, 57 L.Ed. 754 (1913), or interferes with Federal policy, see *Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 639, 93 S.Ct. 1854, 1862, 36 L.Ed. 2d 547 (1973), or it may arise from congressional intent, express or implied, to exclude all State regulation from a particular area. See *Commonwealth v. Federico*, —— Mass. ——, ——, Mass.Adv.Sh. (1981) 1052, 1056, 419 N.E.2d 1374; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522-525, 101 S.Ct. 1895, 1905-1907, 68 L.Ed.2d 403 (1981); *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 324-326, 101 S.Ct. 1124, 1133-1134, 67 L.E.2d 258 (1981). See generally L. Tribe, Ameri-

can Constitutional Law 376-389 (1978). Preemption, however, is not favored, and State laws should be upheld unless a conflict with Federal law is clear. A finding of preemption must rest upon "persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained." *Alessi v. Raybestos-Manhattan, Inc., supra*, 451 U.S. at 522, 101 S.Ct. at 1905, quoting from *Florida Lime & Avocado Growers v. Paul*, 373 U.S. 132, 142, 83 S.Ct. 1210, 1217, 10 L.Ed.2d 248, amended in other respects, 373 U.S. 929, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963).

3. *Does ERISA Preempt § 47B?*

Congress enacted ERISA in 1974 to protect the interests of beneficiaries of employee benefit plans. 29 U.S.C. § 1001 (1976). *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510, 101 S.Ct. 1895, 1899, 68 L.Ed.2d 403 (1981). *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 374-375, 100 S.Ct. 1723, 1732-1733, 64 L.Ed.2d 354 (1980). Prior Federal law[4] had preserved primary responsibility for regulation of benefit plans to the States. See *Malone v. White Motor Corp.*, 435 U.S. 497, 505-512, 98 S.Ct. 1185, 1190-1193, 55 L.Ed. 2d 443 (1978). See generally Hutchinson & Ifshin, Federal Preemption of State Law under the Employee Retirement Income Security Act of 1974, 46 U.Chi.L.Rev. 23, 25-30 (1978). In its place, ERISA outlined a detailed system for Federal regulation of benefit plan administration. *Alessi v. Raybestos-Manhattan, Inc., supra*, 451 U.S. at 510, 101 S.Ct. at 1899.

ERISA applies to two types of benefit plan—"pension plans," which provide retirement benefits or deferred income;[5] and "welfare plans," which provide nonpension

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[4] The Welfare and Pension Plans Disclosure Act of 1958, Pub.L. No.85-836, 72 Stat. 997 (1958) (repealed 1974, 29 U.S.C. § 1031[a][1] [1976]).

[5] 29 U.S.C. § 1002(2) (1976).

benefits including medical and hospital expenses.[6] *Wadsworth v. Whaland*, 562 F.2d 70, 74 (1st Cir. 1977), cert. denied, 435 U.S. 980, 98 S.Ct. 1630, 56 L.Ed.2d 72 (1978). ERISA's regulatory provisions establish disclosure requirements and fiduciary standards applicable to both pension and welfare plans,[7] as well as funding and vesting requirements applicable only to pension plans.[8] Other sections of the act provide for enforcement and administration, and for national insurance against termination of pension plans. See generally, Hutchinson & Ishfin, *supra* at 30-34.

ERISA also contains express provisions defining its preemptive effect on State law. Three provisions are relevant here. First, the act's general preemption clause states in sweeping terms that ERISA supersedes all State laws that "relate to" employee benefit plans.[9] This general clause, however, is followed by a savings clause that exempts any State law that "regulates insurance" from the preemptive effect of the act.[10] The savings clause is

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[6] 29 U.S.C. § 1002(1) (1976).

[7] 29 U.S.C. §§ 1021-1031 (reporting and disclosure); §§ 1101-1114 (fiduciary responsibility) (1976).

[8] 29 U.S.C. §§ 1051-1061 (participation and vesting); §§ 1081-1086 (funding) (1976).

[9] 29 U.S.C. §§ 1144(a) (1976) provides in relevant part that: "Except as provided in subsection (b) of this section, the provisions of . . . [ERISA] shall supersede any and all laws insofar as they may now or hereafter relate to any employee benefit plan." The term "employee benefit plan" refers to both pension plans and welfare plans. 29 U.S.C. § 1002(3) (1976).

[10] "Except as provided in subparagraph (B) [the "deemer" limitation discussed *infra*], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). This exemption is in accord with the McCarran-Ferguson Act, 15 U.S.C. § 1011-1015 (1976), which establishes a Federal policy in favor of State regulation of insurance. See *SEC v. National Sec., Inc.*, 393 U.S. 453, 458-460, 89 S.Ct. 564, 567-568,

limited in turn by a third clause which provides that a State may not "deem" that a benefit plan is an insurer subject to its insurance laws.[11]

The Attorney General argues that § 47B is a law that "regulates insurance," and is therefore exempted from preemption by ERISA's savings clause. The defendants argue that because the purpose and effect of § 47B are to regulate benefits, it should not be saved from preemption as an insurance law.

Persuasive authority supports the Attorney General's position. Both the United States Court of Appeals for the First Circuit and the Supreme Court of New Hampshire have rejected preemption challenges to a New Hampshire law nearly identical to § 47B.[12] *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 410 A.2d 635 (1979). The defendants suggest that these decisions are not soundly reasoned, and have been undermined by a recent decision of the United States Supreme Court, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed. 2d 403 (1981). We disagree. In light of the *Alessi* deci-

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21 L.Ed.2d 668 (1969); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), cert. denied, 435 U.S. 980, 98 S.Ct. 1630, 56 L.Ed.2d 72 (1978).

[11] "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B) (1976).

[12] Like § 47B, the New Hampshire statute, N.H.Rev.Stat.Ann. § 415:18-a (Supp. 1979), requires insurers to include minimum mental health care benefits in all group policies covering hospital or medical expenses. The New Hampshire law does not apply directly to employee benefit plans, as does § 47B. As we have noted, however, the provision in § 47B for direct regulation of benefit plans is not before us.

sion, however, we will set forth our reasoning in some detail.

We first address the language of ERISA's preemption and savings provisions, to determine whether Congress has "unmistakably . . . ordained" preemption of § 47B. *Id.* at 522, 101 S.Ct. at 1905, quoting *Florida Lime & Avocado Growers v. Paul*, 373 U.S. 132, 142, 83 S.Ct. 1210, 1217, 10 L.Ed.2d 248, amended in other respects, 373 U.S. 929, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963). In *Alessi*, the Supreme Court adopted a broad construction of ERISA's general preemption clause, holding that the clause applied to a New Jersey workers' compensation law that prohibited set-offs of workmen's compensation payments against pension benefits. The Court reasoned that the New Jersey statute was a law "relat[ing] to" pension plans because it foreclosed a method of calculating pension benefits. 451 U.S. at 524-525, 101 S.Ct. at 1906-1907. The Court added that "[i]t is of no moment that New Jersey intrudes indirectly, through a workers' compensation law rather than directly, through a statute called 'pension regulation.'" *Id.* at 525, 101 S.Ct. at 1907. See also 29 U.S.C. § 1144(c)(2) (1976).

The Court's analysis in *Alessi* suggests that § 47B is a law that "relate[s] to" benefit plans, within ERISA's general preemption clause. Because a plan that purchases insurance has no choice but to provide mental health care benefits, the insurance provisions of § 47B effectively control the content of insured welfare benefit plans. Although grounds of distinction may exist between *Alessi* and the present case,[13] the Attorney General has not pressed them, and we treat § 47B as a law that "relate[s]

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[13] *Alessi*, which involved State regulation of matters within the scope of ERISA's regulatory provisions (see *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 514-521, 101 S.Ct. 1895, 1901-1905, 68 L.Ed.2d 403 [1981]), does not necessarily undermine the reasoning expressed in *Gast v. State*, 36 Or.App. 441, 452-459, 585 P.2d 12 (1978). See *Alessi, supra* 451 U.S. at 525 n.21, 101 S.Ct. at 1907.

to" employee benefit plans. See *Commonwealth v. Federico*, —— Mass. ——, ————, Mass.Adv.Sh. (1981) 1052, 1055-1056, 419 N.E.2d 1374.

This brings us to the savings clause, which exempts "any law of any state which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (1976). The defendants insist that § 47B is not an insurance law, because it is designed to promote public health,[14] rather than to regulate "traditional" subjects of State insurance. The language of the savings clause, however, is not limited to "traditional" insurance laws, even if such a category could be defined. Contrast *Commonwealth v. Federico*, —— Mass. ——, Mass.Adv.Sh. (1981) 1052, 419 N.E.2d 1374 (savings clause for "generally applicable" criminal laws). The only express limit on the savings clause is the third clause, sometimes called the "deemer" clause, which prevents States from deeming plans to be insurers. See *Wadsworth v. Whaland*, 562 F.2d 70, 77-79 (1st Cir. 1977); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 902, 410 A.2d 635 (1979). On the other hand, we cannot agree with the Attorney General's contention that our analysis should end with the deemer clause. In the Attorney General's view, if § 47B applies to insurance, and does not treat plans as insurers, it is not preempted. See *Wadsworth v. Whaland*, *supra* at 77-78; *Metropolitan Life Ins. Co. v. Whaland*, *supra* 119 N.H. at 902, 410 A.2d 635. We are wary of such a literal reading, which might permit the State, through its insurance laws, to reach far into areas governed by ERISA, and thereby negate the unmistakable intent of Congress to work a broad preemption. The deemer clause is one indication of the intended breadth of the savings clause, but we do not accept it as determinative. We conclude only that the language of the

[14] The public health objectives of § 47B are described at length in the trial judge's findings, and are documented in a post-enactment report of the Joint Committee on Insurance. General Court, Joint Committee on Insurance, Advances in Health Insurance in Massachusetts (August, 1974). See note 24, *infra*.

savings clause is broad enough to permit a construction that would exempt § 47B from preemption. Beyond this, the term "insurance law," and the wording of the deemer clause are of little help.

We prefer to resolve the tension between the general preemption clause and the savings clause by reference to the policies and operation of ERISA, and the general principle that preemption should not be implied unless there is a clear conflict between State and Federal law. *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317-318, 101 S.Ct. 1124, 1130, 67 L.Ed.2d 258 (1981). *Jones v. Rath Packing Co.*, 430 U.S. 519, 525-526, 97 S.Ct. 1305, 1309-1310, 51 L.Ed.2d 604 (1977). Congress, when it enacted ERISA, was concerned with widespread abuses in plan administration, often resulting in employees' losses of anticipated benefits. 29 U.S.C. § 1001(a) (1976). *Wadsworth v. Whaland*, *supra* at 73-74. See *Alessi v Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510, 101 S.Ct. 1895, 1899, 68 L.Ed.2d 403 (1981). In response, Congress enacted rules governing disclosure and fiduciary conduct by administrators of welfare benefit plans.[15] 29 U.S.C. §§ 1001(b), 1021-1031, 1101-1114 (1976). Section 47B has no bearing on the problem of administrative abuse, and does not overlap or interfere with the means chosen by Congress to deal with such abuse. Section 47B affects only the substantive content of plans—a subject completely untouched by ERISA's regulatory provisions. See *Gast v. State*, 36 Or.App. 441, 452-458, 585 P.2d 12 (1978). Therefore, nothing in the practical relationship between the two statutes calls for an implied limitation on the phrase "regulates insurance" that would exclude § 47B from the protection of the savings clause.

The defendants discern an additional "policy" in ERISA's preemption provisions. They suggest that Con-

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[15] In the area of pension plans, Congress also established vesting and funding requirements. 29 U.S.C. §§ 1001(c), 1051-1086 (1976).

gress intended to designate an area of private self-determination with respect to choice of benefits, and to protect it from all State regulation. But the defendants have not identified persuasive evidence in the legislative history of an affirmative policy to curtail State police power in favor of private decision-making. See *Gast v. State*, *supra*, 36 Or.App. at 457-458, 585 P.2d 12. To the contrary, comments during floor debates indicate that broad preemption language was favored in order to provide a clear line of demarcation and to deter States from enacting inconsistent laws on the periphery of ERISA's subject matter.[16] Nor does the Supreme Court's opinion in *Alessi*, *supra*, support the defendants' view that Congress intended to establish strict protection of self-determination in an area outside the scope of ERISA's regulatory provisions. In fact, the Court emphasized in its discussion of preemption that the New Jersey law at issue affected a subject covered by ERISA.[17]

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[16] For example, Congressman John Dent, Chairman of the Subcommittee on Labor of the House Labor and Education Committee, commented that "[w]ith the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974). Senator Jacob Javits, a member of the Senate Committee on Labor and Public Welfare, described the history of the broad general preemption clause in similar fashion: "Both House and Senate bills provided for preemption of State law, but . . . defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29942 (1974). Such statements simply do not reveal a calculated, affirmative design to extend the preemptive effect of ERISA far beyond the reach of the act's regulatory provisions, in order to create an area reserved to unhindered private ordering.

[17] The Court noted that ERISA permitted set-off techniques. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 510, 524, 101 S.Ct. 1895, 1899, 1906-1907, 68 L.Ed.2d 403 (1981). In an earlier section of the

The defendants also contend that ERISA established a policy in favor of uniformity with respect to benefit plans, which would be undermined if States were permitted to impose varying requirements on the substantive content of plans. The defendants point out that businesses that employ workers in a number of different States would be unable to adopt standardized plans covering all of their employees. We are not persuaded by this argument. Congress undoubtedly contemplated a system of uniform, national regulation in the areas governed by ERISA. On the other hand, it specifically approved State regulation in the fields of insurance, banking, and securities, and so could not have intended to mandate complete uniformity for the convenience of multi-state employers. Moreover, the judge below stated in his findings that the defendants had presented "no credible evidence that [diverse State mandatory benefit laws] would be any more complex or burdensome to interstate commerce than various other . . . multi-state regulatory schemes such as workmen's compensation laws."

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opinion, devoted to interpretation of ERISA, the Court also suggested that Congress, by its acquiescence in a prior regulation of the Internal Revenue Service, had authorized the precise set-off technique prohibited by the New Jersey law. *Id.* at 517-521, 101 S.Ct. at 1903-1905.

The defendants cite a statement in the Court's discussion of pre-emption by the NLRA, that "ERISA leaves . . . pension calculation techniques . . . to the discretion of pension plan designers." *Id.* at 525, 101 S.Ct. at 1907. They also quote out of context statements made in the first section of the opinion, which dealt with interpretation of ERISA. There, the Court asked "what defines the content of the benefit that, once vested, cannot be forfeited," and answered that "ERISA leaves this question largely to the private parties . . . . That the private parties, not the government, control the level of benefits is clear from the statutory language defining nonforfeitable rights." *Id.* at 511, 101 S.Ct. at 1900. At most, these statements suggest that private parties control the designation of particular benefits as nonforfeitable—a small area of self-determination well within the scope of ERISA's regulatory provisions (29 U.S.C. §§ 1051-1061 [1976], governing vesting of pension benefits).

In sum, there is no conflict between § 47B and the policies or operation of ERISA that calls for a narrow interpretation of the phrase "regulates insurance" in the savings clause of ERISA's preemption provisions. Therefore, we conclude that ERISA does not preempt § 47B.

4. *Does the NLRA Preempt § 47B?*

Congress enacted the NLRA in 1935 to combat industrial strife by encouraging collective bargaining on terms and conditions of employment. 29 U.S.C. § 151 (1976). The act protects employees' rights to organize and to engage in concerted activity, and defines unfair labor practices by employers and unions. See 29 U.S.C. §§ 157-160 (1976). Certain of the insurance policies issued by the defendants insure plans agreed to through collective bargaining,[18] and the defendants contend that the NLRA preempts application of § 47B to these policies.

The issue of preemption takes a different form under the NLRA than under ERISA. The NLRA does not provide expressly for preemption of State law, as does ERISA. Thus, the NLRA's preemptive effect must be discerned entirely by implication from the policies of the act. On the other hand, Congress clearly did intend, in enacting the NLRA, to mark off an area for autonomous private ordering by labor and management, free from most forms of regulations by either the National Labor Relations Board or the States. *Lodge 76, Int'l Ass'n of Machinists v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132, 140, 96 S.Ct. 2548, 2553, 49 L.Ed.2d 396 (1976) (hereinafter *Machinists*). *Local 24, Int'l Bhd. of Teamsters v. Oliver*, 358 U.S. 283, 295-296, 79 S.Ct. 297, 304-305, 3 L.Ed.2d 312 (1959) (hereinafter *Oliver*).

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[18] In some cases, the underlying collective bargaining agreements specify particular benefits; in other cases, the agreements prescribe only the total amount of the employers' contributions. Our conclusion that the NLRA does not preempt § 47B applies to both forms of agreement.

NLRB v. American Nat'l Ins. Co., 343 U.S. 395, 404, 72 S.Ct. 824, 829, 96 L.Ed. 1027 (1952). Apart from the limits set by Congress, both the economic tactics used during negotiations and the substantive terms of the resulting agreement are "left 'to be controlled by the free play of economic forces.'" *Machinists, supra* 427 U.S. at 140, 96 S.Ct. at 2553, quoting from *NLRB v. Nash-Finch Co.*, 404 U.S. 138, 144, 92 S.Ct. 373, 377, 30 L.Ed.2d 328 (1971). Therefore, when labor and management agree upon subjects of mandatory bargaining, the terms of their agreement "themselves become expressions of federal law, requiring preemption of intrusive state law." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526, 101 S.Ct. 1895, 1907, 68 L.Ed.2d 403 (1981).[19]

Despite the breadth of its statements concerning the preemptive effect of collective bargaining agreements, the Supreme Court has recognized that Congress could not have intended to preempt "all local regulation that touches or concerns in any way the complex interrelationships between employees, employers and unions; obviously, much of this is left to the States." *Malone v.*

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[19] The Supreme Court's preemption decisions under the NLRA fall into two categories. First, the Court has sometimes invalidated State action because it encroached upon the "primary jurisdiction" of the National Labor Relations Board over matters covered by the act. See, e.g., *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 244-245, 79 S.Ct. 773, 779-780, 3 L.Ed.2d 775 (1959) (State injunction of picketing as an unfair labor practice). A second line of decisions, including those discussed in the text above, is based on implied Congressional intent to reserve to private resolution certain matters not covered by the regulatory provisions of the act. See, e.g., *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 99 S.Ct. 1328, 59 L.Ed.2d 553 (1979); *Lodge 76, Int'l Ass'n of Machinists v. Wisconsin Employment Relations Comm'n*, 427 U.S. 132, 96 S.Ct. 2548, 49 L.Ed.2d 396 (1976); *Local 24, Int'l Bhd. of Teamsters v. Oliver*, 358 U.S. 283, 79 S.Ct. 297, 3 L.Ed.2d 312 (1959). In this second group of decisions, the Court has determined that the NLRA protects both choice of economic tactics, see, e.g., *Machinists, supra*, and choice of substantive terms, see, e.g., *Oliver, supra*, from State regulations.

White Motor Corp., 435 U.S. 497, 504, 98 S.Ct. 1185, 1190, 55 L.Ed.2d 443 (1978), quoting from *Amalgamated Ass'n of St., Elec. Ry. & Motor Coach Employees v. Lockridge*, 403 U.S. 274, 289, 91 S.Ct. 1909, 1919, 29 L.Ed.2d 473 (1971). See *Massachusetts Council of Constr. Employers, Inc. v. Mayor of Boston*, —— Mass. ——, —— — ——, Mass.Adv.Sh. (1981) 2039, 2045-2046, 425 N.E.2d 346, cert. granted, —— U.S. ——, 102 S.Ct. 1273, 71 L.Ed.2d —— (1982). Accordingly, the Court has acknowledged a number of exceptions to NLRA preemption, each based upon the probability that Congress did not intend to displace a particular type of State regulation. Preemption will not be implied when Congress has indicated in other Federal legislation that State law should govern a certain area,[20] or when "the activity regulated [is] a merely peripheral concern of the [NLRA]." *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 243, 79 S.Ct. 773, 779, 3 L.Ed.2d 775 (1959).[21] The

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[20] In *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978), the Court held that the NLRA did not preempt a State law governing pension funding, on the ground that a Federal statute, the predecessor of ERISA, demonstrated congressional intent to permit State regulation of the field. In *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 99 S.Ct. 1328, 59 L.Ed.2d 553 (1979), the Court relied heavily upon the Social Security Act of 1935 in upholding a State law granting unemployment benefits to striking workers from revenue collected in part from the struck employers. *Id.* at 536-544, 99 S.Ct. at 1339-1343 (plurality opinion); *id.* at 547, 99 S.Ct. at 1344 (Blackmun, J., concurring).

[21] In *International Ass'n of Machinists v. Gonzales*, 356 U.S. 617, 78 S.Ct. 923, 2 L.Ed.2d 1018 (1957), cited by the Court after the statement quoted in the text, *supra*, the Court held that a State contract action against a union for wrongfully expelling a member was not preempted. See also *Massachusetts Elec. Co. v. Massachusetts Comm'n Against Discrimination*, 375 Mass. 160, 173-175, 375 N.E.2d 1192 (1978) (pregnancy benefits peripheral). The First Circuit, in *Wadsworth v. Whaland*, 562 F.2d 70, 79 (1st Cir. 1977), relied in part on the "peripheral concern" exception in holding that the NLRA did not preempt New Hampshire's mandatory mental health benefit statute, which is analogous to § 47B (see note 12 *supra*).

Court has also upheld State laws when "the regulated conduct touched interests . . . deeply rooted in local feeling and responsibility," *id.* at 244, 79 S.Ct. at 779,[22] and has suggested an exception for "local health or safety regulation[s]," *Oliver, supra* 358 U.S. at 297, 79 S.Ct. at 305.[23]

Section 47B affects health benefits, a subject of mandatory collective bargaining. See *Allied Chem. & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co., Chem. Div.*, 404 U.S. 157, 159, 92 S.Ct. 383, 387, 30 L.Ed.2d 341 (1971). It does not, however, regulate labor-management relations as such; its purpose is to protect public health,[24] and its method is regulation of insurers and in-

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[22] The Court has applied this exception in upholding State authority to entertain tort actions arising out of labor disputes. See, e.g., *Linn v. United Plant Guard Workers, Local 114*, 383 U.S. 53, 60, 86 S.Ct. 657, 661-662, 15 L.Ed.2d 582 (1966). But see *Massachusetts Elec. Co. v. Massachusetts Comm'n Against Discrimination*, 375 Mass. 160, 173-175, 375 N.E.2d 1192 (1978).

[23] The Court has not actually applied this exception. It did, however, recognize the exception in a more recent decision involving a State law affecting the substantive terms of a collective bargaining agreement. *Malone v. White Motor Corp.*, 435 U.S. 497, 513 n.13, 98 S.Ct. 1185, 1194 n.13, 55 L.Ed.2d 443 (1978).

[24] A report of the Joint Committee on Insurance of the General Court, incorporated into the findings of the judge below, demonstrates that the Legislature was concerned with the spread of mental illness among workers and among the poor. In the committee's view, mental health insurance programs would encourage community-based, out-patient care and decrease the need for institutionalization. "Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today." General Court Joint Committee on Insurance, Advances in Health Insurance in Massachusetts 9 (1974). The defendants point to the committee's statement that "the organized worker had a higher rate of mental illness than the rich," and suggest that the committee was specifically concerned with labor relations. This statement, however (which was simply a description of the results of a Yale study), as well as other refer-

surance policies. Ordinarily, preemption depends upon the *effect* of State law upon NLRA policy, and the fact that a State law is enacted for neutral purposes and applies outside the employment relationship cannot save it from preemption. *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 244, 79 S.Ct. 773, 779, 3 L.Ed.2d 775 (1959); *Oliver, supra* 358 U.S. at 297, 79 S.Ct. at 305. See *John Hancock Mut. Life Ins. Co. v. Commissioner of Ins.*, 349 Mass. 390, 400, 208 N.E.2d 516 (1965). See also *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 550-551, 99 S.Ct. 1328, 1346-1347, 59 L.Ed.2d 553 (1979) (Blackmun, J., concurring, joined by Marshall, J.), 557-558, 99 S.Ct. 1349-1350 (Powell, J., dissenting, joined by Burger, C. J., and Stewart, J.). Nevertheless, the various exceptions described above suggest that the character and purpose of the State law may bear upon congressional intent to subordinate it to the NLRA's policy of free collective bargaining.

At least two of the exceptions recognized by the Court are relevant to the validity of § 47B. The first of these is the exception for public health laws, suggested by the Court's statement in *Oliver* that, "We have not here a case of a collective bargaining agreement in conflict with a local health or safety regulation; the conflict here is between the federally sanctioned agreement and state policy which seeks specifically to adjust relationships in the world of commerce." 358 U.S. at 297, 79 S.Ct. at 305. (See note 23 *supra*). Section 47B appears to us to be the type of permissible health regulation envisioned by the *Oliver* court. Section 47B is designed to solve a serious health problem, rather than to alter the bargaining positions of unions and employers. It is unlikely that

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ences to "workers," simply indicates the Legislature's recognition of the impact of mental illness on members of the working classes. It does not reveal an intent to alter the relative economic positions of organized labor and management. Cf. Cox, Labor Law Preemption Revisited, 85 Harv.L.Rev. 1337, 1352 (1972).

Congress intended, by enacting the NLRA, to bind the hands of State Legislatures with respect to problems such as mental health. And because § 47B is addressed to a statewide health problem not peculiar to employment relationships, its exemption will not open a door to State interference with the "free play of economic forces" between labor and management. See Cox, Labor Law Preemption Revisited, 85 Harv.L.Rev. 1337, 1352 (1972).

A second indication that Congress did not intend the NLRA to preempt laws such as § 47B can be found in another Federal statute, the McCarran-Ferguson Act. 15 U.S.C. §§ 1011-1015 (1976). *Wadsworth v. Whaland*, 562 F.2d 70, 79 n.44 (1st Cir. 1977); *Metropolitan Life Ins. Co. v. Whaland*, 119 N.H. 894, 905-906, 410 A.2d 635 (1979). See *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978). See also note 20, *supra*. The McCarran-Ferguson Act establishes a congressional policy in favor of State regulation of insurance, and provides that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b) (1976). Although the purposes and effect of § 47B extend beyond regulation of insurance as such, the statute operates upon insurance and insurance policies. The McCarran-Ferguson Act does not contain a limiting definition of the term "business of insurance," see *SEC v. National Sec., Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed.2d 668 (1969), and we do not believe that conflict between § 47B and the NLRA is serious enough to call for a narrow reading that would exclude § 47B from the act's protection.[25]

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[25] The defendants point out that the McCarran-Ferguson Act provides that it should not be construed to affect the "application to the business of insurance of the [NLRA]." 15 U.S.C. § 1014 (1976). The most reasonable interpretation of this provision is that labor-management relations within insurance companies are subject to the

Finally, § 47B is not an absolute limit on the parties' freedom to negotiate the terms of employee health plans. The provisions of § 47B now before us apply to insurers. They do not mandate the inclusion of mental health benefits in employee plans unless the parties decide to purchase insurance. In view of the need to accommodate the "separate spheres of governmental authority preserved in our federalist system," *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522, 101 S.Ct. 1895, 1905, 68 L.Ed.2d 403 (1981), we hesitate to extend the implied preemptive reach of the NLRA to such a law.

In sum, § 47B imposes some limits on the freedom of labor and management to bargain for health benefit terms, but does so only as an incident of the parties' decision to purchase insurance. At least two of the factors that the Supreme Court has identified as indicia of congressional intent to tolerate particular State legislation despite its effect on collective bargaining pertain to § 47B. Applying the principle that an "exercise of federal supremacy is not lightly to be presumed," *id.*, quoting *Schwartz v. Texas*, 344 U.S. 199, 203, 73 S.Ct. 232, 235, 97 L.Ed. 231 (1952), we conclude that the NLRA does not preempt § 47B.

5. *Application of § 47B to Policies Issued before 1976.*

The defendants' final contention is that § 47B does not and cannot apply to certain policies issued before its effective date (January 1, 1976), under which termination or renewal is at the option of the policyholder. These policies either do not permit the defendants to refuse to continue coverage, or permit refusal in limited circumstances

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NLRA. See *John Hancock Mut. Life Ins. Co. v. Commissioner of Ins.*, 349 Mass. 390, 398, 208 N.E.2d 516 (1965). The reading suggested by the defendants—that the implied preemptive effect of the NLRA extends to insurance regulation—is not a reasonable interpretation.

only. All of the policies, however, authorize the defendants to raise premium rates. The judge found that since January, 1976, the defendants have raised premium rates for almost all policies, and that in many instances the parties have altered benefit coverage as well. The judge ordered the defendants to provide the benefits required by § 47B under policies that were "issued prior to January 1, 1976, but . . . have been *altered or renewed through any change in premium or benefits*" (emphasis added). We interpret this order to require the defendants to provide benefits from the date of alteration under policies altered since January 1, 1976.

Section 47B applies by its terms to policies "issued or subsequently *renewed by agreement between the insurer and the policyholder*" after its effective date (emphasis added). We agree with the judge that "renew[al] by agreement" includes changes in benefits or premiums. A change in benefit coverage is in effect an agreement to a new policy, whatever the label applied by the parties. An insurer's decision to raise premiums presents a closer question; the insurer has not actually assented to continued coverage. Nevertheless, we believe that an insurer's adjustment of its compensation, coupled with the insured's acceptance of the new rates, amounts to renewal for purposes of § 47B. Section 47B is designed to enable as many Massachusetts residents as possible to receive mental health coverage. The provision limiting its application to policies newly issued or renewed is best read as a measure to ensure that insurance companies can adjust their rates to reflect the new risks imposed.

This application of § 47B does not conflict with the contract clause of the United States Constitution, art. 1, § 10. Although the Supreme Court has confirmed in recent decisions that the contract clause imposes substantial limits on the power of States to alter contractual obligations, it remains clear that the prohibition against impairment of contract is not absolute. See *Allied Struc-*

tural Steel Co. v. Spannaus, 438 U.S. 234, 98 S.Ct. 2716, 57 L.Ed.2d 727 (1978); *United States Trust Co. v. New Jersey*, 431 U.S. 1, 97 S.Ct. 1505, 52 L.Ed.2d 92 (1977). Private contract rights are subject to reasonable and necessary legislation in furtherance of important public interests, and legislative judgments concerning reasonableness and necessity are entitled to deference. *Allied Structural Steel Co. v. Spannaus*, *supra*, 438 U.S. at 244, 98 S.Ct. at 2722; *United States Trust Co. v. New Jersey*, *supra*, 431 U.S. at 22-23, 97 S.Ct. at 1517-1518. The Supreme Court has approached issues arising under the Contract Clause by assessing the relative weight of the impairment and the State's interest in enacting the impairing legislation. See *Allied Structural Steel Co. v. Spannaus*, *supra*, 438 U.S. at 244-250, 98 S.Ct. at 2722-2725.

The impairment wrought by § 47B is minimal. The defendants must provide insurance against a risk they did not assume in the original policies. The risk imposed by § 47B, however, does not affect the defendants retroactively; benefits are due only from the date on which the policies were issued or amended, and in no case before the effective date of the statute. Contrast *American Mfrs. Mut. Ins. Co. v. Commissioner of Ins.*, 374 Mass. 181, 372 N.E.2d 520 (1978) (mandatory premium rebates); *Allied Structural Steel Co. v. Spannaus*, *supra* (increased pension liability). Moreover, the defendants' policies permit them to counteract the new risk by raising premium rates. Contrast *Allied Structural Steel Co. v. Spannaus*, *supra* at 246-247, 98 S.Ct. at 2723-2724. Thus, the defendants—participants in a heavily regulated industry—[26] cannot complain of a serious interference with their reasonable expectations.

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[26] See *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 250, 98 S.Ct. 2716, 2725, 57 L.Ed.2d 727 (1978). See also G.L. c. 174-175F; *American Mfrs. Mut. Ins. Co. v. Commissioner of Ins.*, 374 Mass. 181, 193, 372 N.E.2d 520 (1978).

The State interest supporting § 47B—protection of the public health—is an important one, and the means selected to further it are reasonable. Section 47B applies generally to all insurers that issue policies to Massachusetts residents. Contrast *Allied Structural Steel Co. v. Spannaus, supra* at 250, 98 S.Ct. at 2725. Its application to policies altered after January 1, 1976, is reasonable and necessary to accomplish its objective of ensuring broad mental health coverage. Exclusion of such policies would permit insurance companies to avoid much of the effect of future insurance laws at no cost, by entering contracts characterized as perpetual, while retaining the right to raise premium rates. Without determining the full extent to which the State's interest in a broad application of mandatory benefit laws would justify impairment of private contracts, we believe that it overrides the minimal private interests here at stake.

We conclude that the application of § 47B at issue is severable from the application of § 47B that the parties have assumed to be invalid, and is not preempted by ERISA or the NLRA. With respect to policies issued since January 1, 1976, the judge correctly ordered the defendants to comply with § 47B from the date of issuance. With respect to policies issued before January 1, 1976, and altered or renewed through any change in premium or benefits after January 1, 1976, the judge correctly ordered the defendants to comply from the date of alteration.

Judgment affirmed.

APPENDIX B

COMMONWEALTH OF MASSACHUSETTS.

SUPREME JUDICIAL COURT FOR THE COMMONWEALTH
AT BOSTON

March 24, 1982

In the Case No. SJC-2542

ATTORNEY GENERAL

vs.

THE TRAVELERS INSURANCE COMPANY

pending in the Superior Court Department of the Trial Court for the County of Suffolk, No. 35598.

ORDERED, that the following entry be made in the docket; viz., —

Judgment affirmed.

BY THE COURT,

/s/ Patrick M. Hurley, CLERK.

March 24, 1982.

See opinion on file.

APPENDIX C

COMMONWEALTH OF MASSACHUSETTS

SUPERIOR COURT

SUFFOLK, SS:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS

v.

THE TRAVELERS INSURANCE COMPANY and
METROPOLITAN LIFE INSURANCE COMPANY

FINDINGS AND CONCLUSIONS PURSUANT TO MASS.R.CIV.P. 52

Based on all the credible evidence and the reasonable inferences therefrom, the Court makes the following findings:

1. This is an action brought by the Attorney General of the Commonwealth of Massachusetts requesting declaratory judgment and injunctive relief.

2. The plaintiff has sent and the defendants have each received notice, pursuant to G.L. c. 93A, § 4, of the intention of the Attorney General to file suit to enforce the provisions of G.L. c. 175, § 47B.

3. The Commonwealth of Massachusetts is a sovereign state of the United States represented by the Attorney General.

4. The Travelers Insurance Company is a corporation duly organized and existing under the laws of the State

of Connecticut, with a principal address at One Tower Square, Hartford, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

5. Metropolitan Life Insurance Company is a corporation duly organized and existing under the laws of the State of New York, with a principal address at One Madison Avenue, New York, New York, and is duly authorized to operate as a foreign insurance company in the Commonwealth.

6. At all times relevant hereto, the defendant insurance companies have been authorized by the Commissioner of Insurance, pursuant to G.L. c. 175, § 150, to engage in the business of insurance in the Commonwealth.

7. The defendants each engage in the business of insurance in other states of the United States of America.

8. In the course of its business, each of the defendant insurance companies issues group insurance policies to policyholders which provide coverage for hospital and surgical expenses for subscribers of the group insurance policies who are residents of the Commonwealth of Massachusetts.

9. I find that many of the defendant insurance companies' group insurance policies are issued to implement employee welfare benefit plans.

10. General Laws Chapter 175, Section 47B was enacted on December 10, 1973, effective January 1, 1976, and provides as follows:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten*, which provides hospital expense and surgical expense insurance and which is

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* Section 110 refers to eligible groups which may be covered under group health insurance policies issued in Massachusetts.

issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth while this provision is effective shall, provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital (3) or subject to the

approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultation or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause "psychotherapist" shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry.

11. The defendant insurance companies have issued numerous group insurance policies since January 1, 1976, to policyholders situated outside the Commonwealth of Massachusetts which provide benefits for hospital and surgical expenses to subscribers who are residents of the Commonwealth.

12. Certain of these policies do not provide coverage for Massachusetts resident subscribers for mental and nervous conditions mandated by G.L. c. 175, § 47B.

13. The defendant insurance companies have offered to issue group insurance policies to prospective policyholders outside the Commonwealth which will provide benefits for Massachusetts resident subscribers.

14. The defendant insurance companies have issued group insurance policies, effective prior to January 1, 1976, which contain no "renewal" clause among the policy terms. Such policies provide the defendants with the unilateral right to increase premiums on each such policy. The defendants and their policyholders may alter other policy terms and benefits by agreement. Such policies have been issued both within and outside the Commonwealth providing coverage to Massachusetts resident subscribers.

15. Since January 1, 1976, each of the defendants have increased the premiums, or altered the policy terms, or both, by agreement with the policyholders of the policies described in paragraphs 13 and 14.

16. Where the group insurance policies issued by the defendant insurance companies have been renewed or reissued since January 1, 1976, through the payment of increased or renewed premiums, or the alteration of policy benefits, the defendants have failed in each instance to provide to subscribers who are residents of the Commonwealth the coverage and benefits for mental and nervous conditions mandated by G.L. c. 175, § 47B.

17. The defendant insurance companies have denied coverage and benefits arising from mental and nervous conditions mandated by G.L. c. 175, § 47B to Massachusetts resident subscribers of group insurance policies issued by them on various grounds, including:

(a) the policy contains no provision for renewal, and is subject to continuation at the option of the policyholder, and therefore is not subject to § 47B;

(b) the policy is issued to a qualified employee welfare benefit plan and, therefore, state law is preempted by ERISA;

(c) § 47B may not be applied extraterritorially to a policy issued outside of Massachusetts. The application of § 47B to a policy issued outside of Massachusetts violates the U.S. Constitution;

(d) where the application of § 47B would have the effect of altering benefits subject to collective bargaining, it is preempted by the National Labor Relations Act.

18. Metropolitan Life Insurance Company ("Metropolitan") has approximately 80 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976, and

which provide medical expense coverage to approximately 40,400 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 39,228 and outside of the Commonwealth of Massachusetts is substantially more. All actions with respect to the changing of premiums or benefits for those policies issued outside of Massachusetts took place outside of the Commonwealth of Massachusetts.

19. Metropolitan has approximately 28 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976, and which provide medical expense coverage to approximately 3,528 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massacahusetts is 2,291 and outside of the Commonwealth of Massachusetts is substantially more. All actions with respect to the changing of premiums or benefits for those policies issued outside of Massachusetts took place outside of the Commonwealth of Massachusetts.

20. Metropolitan has approximately 33 group insurance contracts in force which were issued within the Commonwealth of Massachusetts prior to January 1, 1976, and which provide medical expense coverage to approximately 8,600 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 8,253 and outside of the Commonwealth of Massachusetts is approximately 6,852.

21. Metropolitan has approximately 28 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976, and which provide medical expense coverage to approximately 20,100 Massachusetts employees. To the extent data is available, the approximate number of employees residing within Massachusetts is 19,874 and outside of the Commonwealth of Massachusetts is 21,235.

22. The Travelers Insurance Company ("Travelers") has approximately 57 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts prior to January 1, 1976, and which provide medical expense coverage to approximately 14,000 Massachusetts employees. There are substantially more employees residing outside of the Commonwealth. All actions with respect to the changing of premiums or benefits for those policies issued outside Massachusetts took place outside the Commonwealth of Massachusetts.

23. Travelers has approximately 27 group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts on or after January 1, 1976, and which provide medical expense coverage to approximately 13,000 Massachusetts employees. There are substantially more employees residing outside of the Commonwealth. All actions with respect to the changing of premiums or benefits for those policies issued outside Massachusetts took place outside the Commonwealth of Massachusetts.

24. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth of Massachusetts and which provide medical expense coverage to approximately 45,000 Massachusetts employees. Of these contracts, an estimated 60% to 70% were issued prior to January 1, 1976.

25. Virtually all of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). There are, however, a few such contracts issued to provide benefits for plans not subject to ERISA, such as church or government plans as defined in ERISA. With respect to all or virtually all Metropolitan policies, Metropolitan acts as the named fiduciary for the review of denied claims pursuant to ERISA. (For reference see Exhibit G.)

26. Metropolitan has approximately 49 group insurance contracts in force which were issued within the Commonwealth of Massachusetts on or after January 1, 1976, or which were issued within the Commonwealth of Massachusetts before January 1, 1976, and for which Metropolitan reserved the unilateral right to non-renew the contract, and which provide the benefits specified in G.L. c. 175, § 47B. Travelers has approximately 2,150 group insurance contracts in force which were issued within the Commonwealth and which provide the benefits specified in G.L. c. 175, § 47B. As a matter of policy and voluntary decision, the defendants and those policyholders have provided the benefits specified by G.L. c. 175, § 47B.

27. Certain of Metropolitan's and Travelers' group insurance contracts in force providing medical expense coverage to Massachusetts employees were issued to provide benefits for employee benefit plans which are the product of collective bargaining agreements negotiated subject to the National Labor Relations Act. Certain of these collective bargaining agreements prescribe the particular type and level of medical expense benefits to be afforded employees while others prescribe the level or amount of contributions to be afforded employees, and the particular group insurance contract which implements the terms of the collective bargaining agreement.

28. The preponderance of insurance policies affected by G.L. c. 175, § 47B have been issued to employers. A substantial number of these employers engage in business operations in other states as well as in Massachusetts, and have employees who live and work in such other states as well as in Massachusetts.

29. The Commonwealth is not seeking to enforce that part of G.L. c. 175, § 47B purporting to affect employee health and welfare plans directly.

30. The subject of health benefits, including mental health benefits, is a mandatory subject of collective bar-

gaining, as to which employers subject to the National Labor Relations Act have a duty to bargain.

31. More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce. This is also true with respect to Travelers.

More than 20% of the gross revenue from Metropolitan's trade or commerce is derived from transactions in interstate commerce, excluding all transactions and actions which occur primarily and substantially within the Commonwealth. This is also true with respect to Travelers.

32. (a) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1940 through 1975:

> RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding on which last date and on each anniversary of which last date the Employer may renew this Policy for a further term of one year, provided (1) the number of Employees then insured hereunder for Personal Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees, and provided, in either case, the number of Employees then insured hereunder for Personal Insurance is not less than fifty and (2) the number of Employees insured hereunder for Dependent Insurance is, in the case of Contributory Insurance, not less than seventy-five percent of the number of eligible Employees with Dependents and, in the case of Non-Contributory Insurance, not less than the total number of eligible Employees with De-

pendents. Such renewal is conditioned upon the payment of the premium then due as computed in the manner set forth in Section 16 hereof and based upon such premium rates as may then be determined by the Insurance Company.

(b) The following is Metropolitan's standard group insurance contract "Renewal Privilege" provision generally in use for contracts issued from 1976 through 1978. Certain contracts issued in 1975 also contained this provision.

RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a) if the number of Employees then insured for each type of insurance provided hereunder is less than 75% * of the number of Employees eligible for such insurance, or (b) if the number of Employees then insured hereunder is less than 50 *.

(c) Metropolitan group insurance contracts issued in 1979 and thereafter generally do not include a provision labeled "Renewal Privilege". The following is Metropolitan's standard group contract "Discontinuance Of The Policy" provision generally included in group contracts issued in 1979 and thereafter:

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* Although the standard is 50, the number may be greater in certain contracts.

DISCONTINUANCE OF THE POLICY—Metropolitan will have the right to discontinue this Policy if less than 75% * of the eligible Employees are insured for each type of insurance. Metropolitan will also have such right if less than 50 ** Employees are insured. Such right may be exercised by Metropolitan only on the last day of the first Policy Period or on the day before any Premium Due Date which occurs after the last day of the first Policy Period. Notice, in writing, that this Policy is to be discontinued must be given to the Employer by Metropolitan. The notice must be given at least thirty-one days *** prior to the date this Policy is to be discontinued.

(d) Certain large groups have non-standard provisions in their group insurance contracts.

(1) The following "Renewal Privilege" provision forms the basis for the type of provision generally used for these groups:

RENEWAL PRIVILEGE—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, subject to the following provisions. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.

The Insurance Company reserves the right to decline to renew this Policy on any renewal date (a)

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* Change to 100% in the case of non-contributory insurance. Not less than 75% in the case of contributory insurance.

** Although the standard is 50, the number may be greater in certain contracts.

*** Although the standard is 31, the number may be changed to a longer period of up to 90 days in certain contracts.

if the number of Employees then insured for each type of insurance provided hereunder is less than 75% of the number of Employees eligible for such insurance, or (b) by giving at least ninety days prior written notice to the Employer.

(2) The following "Renewal Privilege" provision is an example of a provision presently contained in one such large group contract.

RENEWAL PRIVILEGE—This Policy is issued for a period commencing with the date of issue and ending with the day immediately preceding January 1, 1956, on which last date and on each anniversary of which last date the Employer may renew this Policy for a term of one year, except that the Insurance Company reserves the right to discontinue this Policy of December 31, 1960, or on the day preceding any subsequent renewal date by giving written notice to the Employer at least

33. With respect to virtually every one of the Metropolitan insurance contracts referred to in paragraphs 18 through 21 above, since January 1, 1976, the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

34. The Travelers standard form of group insurance policy, which relates to continuity and discontinuance of the policy and modification of the policy, including premium rate changes, has been virtually unchanged for the past 30 years. (For reference, see Exhibit J, and marked portions).

35. With respect to virtually every one of the Travelers insurance contracts referred to in paragraphs 22 and

23 above, since January 1, 1976 the specific benefits provided pursuant to each particular contract and the premium paid under that contract have changed. This is also true with respect to a substantial number of the Travelers insurance contracts referred to in paragraph 24 above. With respect to virtually all of those insurance contracts, premiums have increased to account for inflation as well as expansions of the benefit package. It is common for the premiums of many of those contracts to be increased annually.

36. Exhibits K and L are copies of current model or sample provisions for major medical expense benefits, including mental health benefits which are offered by Metropolitan and Travelers, respectively, to their policyholders. These provisions are used in the absence of policy holder requests for different provisions. A substantial number of times they are accepted by policyholders.

37. Certain of Metropolitan's and Travelers' insurance contracts have undergone changes in the areas of mental health, retirees or surgical benefits or in other related areas of benefits or eligibility. [Examples of such changes in the areas of mental health, retirees and surgical benefits are Exhibits M (Metropolitan) and N (Travelers) for reference].

38. With respect to G.L. c. 175, § 47B ("Section 47B"), there is: (a) substantial compliance by Metropolitan and substantial noncompliance by Travelers with Section 47B(a); (b) substantial compliance by Metropolitan and Travelers with Section 47B(b); and (c) substantial noncompliance by Metropolitan and Travelers with Section 47B(c).

39. With respect to certain of the Metropolitan and Travelers policies, each of the defendants has denied claims by Massachusetts residents for mental health care benefits that otherwise would have been paid if the policies had contained the provisions specified in G.L. c. 175, § 47B.

40. During the years 1976-1980, the Commonwealth of Massachusetts expended the following amounts for institutional mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980
87.6	86.8	93.1	96.4	88.4 Million

During the years of 1976-1980, the Commonwealth of Massachusetts expended the following amounts for community based mental health care, including care for alcoholism and drug abuse, and for all other mental and nervous disorders.

1976	1977	1978	1979	1980
26.8	36.8	45.1	60.5	108.3 Million

These funds are distributed to public and private community mental health centers, and other community mental health organizations, a substantial number of which derive a substantial portion of their revenue from third party insurance payments.

41. Virtually all claims submitted by or on behalf of Massachusetts residents pursuant to Metropolitan's group insurance contracts in force are received, reviewed, processed, and paid or denied outside of the Commonwealth of Massachusetts. In certain cases, Metropolitan policyholders with operations within the Commonwealth will be responsible for the actual transmission of claims from employees to Metropolitan.

42. With respect to certain of Travelers' group insurance contracts in force which were issued outside of the Commonwealth of Massachusetts, claims submitted by or on behalf of Massachusetts residents pursuant to such contracts are received, reviewed, processed and paid or denied outside of the Commonwealth. With respect to certain other of Travelers' contracts in force which were issued outside of the Commonwealth, including the con-

tract issued to G.T.E., some claims are received, reviewed, processed and paid or denied within the Commonwealth and some claims are received, reviewed, processed and paid or denied outside the Commonwealth.

43. The policy clauses referred to in paragraph 32(a) and (b) of these findings and the marked clauses referred to in paragraph 34 are contained in many of defendants' group insurance contracts in force covering Massachusetts residents and issued prior to January 1, 1976. Under these clauses, a policyholder may exercise its right to non-renew or discontinue its contract even if claims paid and expenses incurred by the insurer exceeded premium payments made to the insurer. This may leave the insurer with a net loss under the contract which it would be unable to recover from the policyholder. Even if the policyholder does not non-renew or discontinue the contract under those circumstances, the insurer will often be unable to recover the loss during the subquent year.

44. There are approximately 82 community mental health centers and clinics subject to reimbursement pursuant to G.L. c. 175, § 47B(c)(3).

45. The inpatient population of Massachusetts state mental hospitals has decreased from approximately 13,482 in 1969 to approximately 2,328 in 1980.

46. In general, the voluntary insurance market has been deficient in providing coverage for certain benefits, including treatment for mental or nervous conditions, due to the phenomenon of adverse selection as well as the fact that benefits for such coverage extend beyond the individual user.

47. Adverse selection operates where the insured individuals are able to identify themselves as good or bad risks. This is often true for mental or nervous conditions. Insurance companies must price coverage at the average or expected cost of treatment. However, if good

risks (i.e. those individuals who do not perceive a need for the particular benefit being offered) avoid the coverage, the insurance company no longer is providing insurance to an average group, since it is dominated by bad risks (i.e. those who are in need of the particular benefit). Where the legislature mandates coverage for mental and nervous conditions, it facilitates consumer preferences and produces a normal competitive market. Thus, each person is able to receive coverage at the "average" price for the group, thus spreading the risk.

48. Mental illness is a major and exceedingly costly national health problem. The direct costs of treatment are staggering, yet they are exceeded by indirect costs. Indirect costs are the income or income-equivalent losses which result from deaths due to mental illness, total disability due to mental illness and the loss of productive time to those individuals who are institutionalized or who utilize outpatient therapy.

49. At a total cost of about $15 billion, mental illness is dealt with by means other than treatment by health personnel, including police, welfare and other social agencies. Taxes support social services at V.A. hospitals, taxes and insurance premiums together pay for 90% of hospital expenses and 70% of physicians' charges. These social expenditures are made collectively.

50. The impact of G.L. c. 175, § 47B will result in additional premium costs. However, this impact is only manifested by a shift in the source of payment for treatment of mental or nervous conditions. There is no data by which shifts in costs and additional costs can be separated.

51. The important social benefits which accrue from the increased availability of treatment for mental or nervous conditions, include increases in employment productivity and decreases in utilization of other non-psychiatric medical care.

52. The legislative intent behind the enactment of G.L. c. 175, § 47B was reported by the Joint Insurance Committee of the General Court, as follows:

a. Mental illness strikes indiscriminately among young and old, rich and poor. A need therefore exists for all people to be safeguarded against the high and sometimes crippling costs of professional mental health care today.

b. It has been demonstrated that mental health insurance is insurable at a reasonable cost for groups. Blue Cross indicates only a slight increase for non-group subscribers over what group members now pay for mental health benefits.

c. There is a growing trend in this state towards community mental health care. No longer will institutionalization be the answer for the majority of the mentally ill.

Instead, out-patient treatment delivered close to home at early stages will be tomorrow's answer. In order to enlarge this system and make it available to millions of Massachusetts residents, mental health insurance must be mandatory in our health insurance policies sold in this commonwealth.

d. Studies show that people who have mental health insurance do not abuse it, even with no limit to the number of services and with no co-payment. Mental health benefits are moderately utilized.

e. Mental health insurance significantly reduces the amount of non-psychiatric medical care to a given population. This indicates that people who do not have mental health insurance either wait until their illness physically affects them, or are being treated in a manner not appropriate to the illness.

f. There is a great potential for increased revenue to the commonwealth, because of 3rd party payments from insurance companies. Connecticut in their first year of

their mental health insurance bill realized an increase in third party payments in the amount of 1.5 million dollars—an increase of approximately sixty percent. If Massachusetts had proportionately the same success with third party payments as Connecticut, a sixty percent increase could mean an additional six million dollars in revenue. Although this increase is a very optimistic one, the potential for increase revenue is there.

g. The most humanitarian reason for mandatory mental health insurance against the mentally ill is ended. It means that the state, by making mental health insurance mandatory on all policies, officially recognized that mental illness is a health problem that all must be protected against. No longer will the mentally ill be forced to go to a public institution instead of a local private institution because they could not get mental health insurance.

53. Since January 1, 1976, the effective date of G.L. c. 175, § 47B, a number of observable changes have occurred in the market for treatment of mental and nervous conditions in Massachusetts.

a. There has been a dramatic shift from in-patient to out-patient delivery of treatment for mental and nervous conditions.

b. The number of providers of out-patient treatment for mental and nervous conditions has increased.

c. The socioeconomic mix of persons receiving treatment for mental and nervous conditions has changed dramatically. Whereas these services were provided on an out-patient basis primarily to upper middle class and wealthy clients prior to January 1, 1976, a large percentage of the total today are poor, working and middle class persons.

54. The defendants failed to seek declaratory or other relief in this matter.

55. No credible evidence was produced regarding the additional premium cost impact of the Massachusetts mandated benefit statute. Specifically, evidence which would have substantiated the fact that, the defendants in providing medical health benefits to Massachusetts residents, would be unable to absorb the annual $500 cost of providing a minimum mental health benefit mandated by G.L. c. 175, § 47B.

56. There is a direct correlation between the premium cost impact of a mandated benefit statute and the recovery limit. Section 47B provides for a minimum recovery of $500. It is a logical inference that the limit of $500 would have a direct relationship to a restricted increase, if any, in premium cost.

57. Mandated benefit laws do impose an administrative burden. However, the diversity of eligibility requirements for each state for example, would not be any more complex or burdensome to interstate commerce than various other diverse multi-state regulatory schemes such as workmen's compensation laws.

58. There is no credible evidence that a single plan in the United States has gone bankrupt because of its compliance with a mandated benefit statute.

59. There is no credible evidence which establishes the amount of additional premium cost which would be incurred if each of the group policies issued by these defendants in fact complied with G.L. c. 175, § 47B.

60. There is no credible evidence which establishes the amount of additional premium which would be incurred if the policies issued by these defendants provided the minimum mental health benefits required by the few mandated benefits statutes which apply extraterritorily to policies issued out of state covering employees or residents within the state.

61. There is no credible evidence which establishes the amount of additional premium which would be re-

quired to provide equal mandatory minimum benefits of various kinds to all persons covered by group insurance contracts nationally.

62. There is no credible evidence that the potential cost impact of § 47B has forced any policyholder of any insurance which has previously complied with § 47B to discontinue such coverage and become a self-insurer.

63. There is no credible evidence that the trend towards self-insurance is more pronounced in Massachusetts by virtue of the enactment of Section 47B. This trend has permeated various types of insurance mechanisms due to the sharply escalating prices for various types of insurance coverage. A few examples include health, product liability and professional liability insurance.

64. The subject of health benefits, including mental health benefits, is a mandatory subject of collective bargaining, as to which employers subject to the National Labor Relations Act have a duty to bargain.

65. It is common for collective bargaining agreements to specifically reserve to the employer the right to alter any portion of the agreement to comply with any applicable change in state or federal law.

66. Collective bargaining agreements differ in many respects from state to state or from bargaining unit to bargaining unit because of the differences in state and local law.

67. There is no credible evidence that the mandated mental and nervous condition benefit statutes are more disruptive to the collective bargaining process than were statutes, such as G.L. c. 151(b), § 5, mandating coverage for pregnancy-related disabilities on the same basis as for other disabilities, prior to the Title VII amendments of the Civil Rights Act in 1979.

68. Among the health benefits which are a mandatory subject of collective bargaining are benefits for treatment

of mental and nervous conditions as well as benefits for pregnancy-related disabilities.

69. Assuming that each state enacted mandated benefits laws and further that eligibility requirements were different for each state, there is no credible evidence that this diversity would be any more complex or burdensome to interstate commerce than various other diverse multistate regulatory schemes such as workmen's compensation laws.

CONCLUSIONS

70. The acts of the Legislature are presumed to be constitutional. *Commonwealth* v. *Henry's Drywall Co. Inc.*, 366 Mass. 539, 541. Thus, the defendants bear the heavy burden of showing an invalid exercise of legislative power or an impermissible infringement of its property rights. *Consolidated Cigar Corp.* v. *Department of Public Health*, 372 Mass. 844, 851.

71. The McCarren-Ferguson Act preserves state insurance statutes from attack under the Commerce Clause. *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408, 431 (1946). Congress has declared that uniformity of regulation is not required in reference to the business of insurance. Thus, Congress recognized that the variations in state regulation of interstate insurance transactions would impose a burden on commerce which otherwise may be subject to challenge under the Commerce Clause. *Lewis* v. *B. T. Investment Managers, Inc.*, 48 U.S.L.W. 4638 (June 9, 1980). But if the Commerce Clause was applicable, the state's interest in substantial health benefits for its residents, the fact that the statute applies evenhandedly to policies issued within and outside of the state, the incidential effect on interstate commerce, the fact that a state has a legitimate interest in relieving itself of a portion of the financial burden of treatment for mental and nervous conditions all combined, give the state the right to exercise its general police powers in the

manner of this legislation. *Metropolitan Life Insurance Company* v. *Whaland*, —— N.H. —— (December 28, 1979); *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

72. Massachusetts may regulate interstate insurance transactions under the due process clause where a legitimate state interest exists in the substance of the transaction. A state may subject out-of-state insurance transactions to its laws where the state has a legitimate interest in regulation. As long as a legitimate state interest exists, the state also has sufficient contacts with the transaction to justify state action. *Osborn* v. *Ozlin*, 310 U.S. 53 (1940). It is obvious that the licensing of the defendant companies is sufficient contact to warrant the legislation. The state has a substantial interest in the business of insurance of its people.

73. The Full Faith and Credit Clause has no application where a state has a direct interest in an interstate insurance transaction. *Watson* v. *Employers Liability Assurance Corp.*, 348 U.S. 66 (1954).

74. G.L. c. 175, § 47B is not preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*; the National Labor Relations Act (NLRA), 29 U.S.C. § 141 *et seq.*; and the Railway Labor Act, 29 U.S.C. § 151 *et seq.*; *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978).

75. G.L. c. 175, § 47B is not a law impairing the obligation of contracts repugnant to the Constitution of the United States. The Contract Clause only protects impairment of contracts issued prior to January 1, 1976, the effective date of § 47B. Both defendant companies have issued group insurance policies that provide medical coverage to Massachusetts employees and residents since the date of the enactment of said legislation.

76. § 47B does not impair existing contracts because defendant insurance companies have formed new con-

tracts originally issued prior to January 1, 1976. The defendant insurance companies have issued complex and elaborate riders which increase premium charges and in some cases have changed the constituency of the employee and dependent groups insured by the original insurance policy. These riders indicate the making of a new contract.

There are five essential elements to an insurance contract: (a) subject matter of the insurance; (b) risk insured against; (c) amount of insurance; (d) duration of risk; (e) premium. *Mann* v. *Charter Oak Fire Insurance Company*, 196 F.Supp. 604, 608 (D.C. Ark. 1961), *aff'd* 304 F.2d 166 (8th cir. 1962). An increase in premiums or a change in any of the remaining essential terms constitutes a new contract. *Ocean Ace and Guaranty Corp.* v. *Combined Locks Paper Co.*, 15 N.W. 156 (Wisc. 1916); 1 Couch on Insurance 2d, § 4.27.

77. The policies have been renewed within the meaning of the statute. Specifically, Metropolitan's policies until 1979 actually contained renewal clauses. Travelers' policies list an anniversary date. Both terms allow the insurer to demand higher premiums in exchange for continuing the policy. This constitutes the issuance of a new contract to which intervening regulatory legislation can be constitutionally applied. *Moore* v. *Metropolitan Life Insurance Co.*, 33 N.Y. 2d 304, 307 N.E. 2d 554 (1973).

78. Any impairment to insurance contracts issued prior to January 1, 1976, caused by § 47B is constitutionally permissible. The act serves a legitimate public purpose and more importantly, the purposes of the act are achieved in a reasonable manner. *Allied Structural Steel Co.* v. *Spannaus*, 438 U.S. 234, 244-245 (1978); *Home Building & Loan Assn.* v. *Blaisdell*, 290 U.S. 398 (1934). The demonstrated public need for basic mental health insurance has been addressed with a reasonable

and precise legislative response. Thus, any impairment of contracts and possible burden on insurers is clearly outweighed by the public interest.

79. The fact that the statute applies to the uninsured and to the insured plans and also that the Commonwealth states for the record that the uninsured provision is unenforceable, alone, does not make the statute unconstitutional. By not striking down the total statute and allowing "the insured" portion to stand, we are preserving as much of the legislative intent as is possible, in a fair application of constitutional principles. *Lowell* v. *Kowalski*, Mass. Adv. Sh. (1980) 1243, 1250; *see also*, 2 C. Sands, Sutherland Statutory Construction, § 44.17, 44.18 (1973); *see also*, *Commonwealth* v. *Baird*, 355 Mass. 746. I uphold the remainder of the statute other than that which is inapplicable, thus "the uninsured" portion, because the statute without the uninsured thrust still has independent force. *Del Duca* v. *Town Administrator of Methuen*, 368 Mass. 1.

80. I rule that the acts of the defendants are not a violation of G.L. c. 93A, § 2(a), and I further rule that the acts of the defendants are not unfair methods of competition nor unfair or deceptive acts or practices. While the plaintiff argues that *Shubach* v. *Household Finance Co.*, Mass. Adv. Sh. (1978) 1153 applies, I do not agree.

Therefore, I order that the defendants are permanently enjoined from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976, or issued prior to January 1, 1976, but which have been altered or renewed through any change in premium or benefits.

This Judgment shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants has not provided the benefits required

by G.L. c. 175, § 47B at any time since January 1, 1976, the defendants shall, within 30 days of this Judgment provide to each such policyholder copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this Judgment. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, FOR WHICH YOU DID NOT RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

The defendants further shall publish within 60 days in at least 3 mental health treatment journals of general circulation the following notice to providers of services who have made direct claims to the defendants, but who have not received reimbursement due to the defendant's noncompliance with G.L. c. 175, § 47B:

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY ANY POLICIES ISSUED BY THE TRAVELERS INSURANCE COMPANY AND THE METROPOLITAN LIFE INSURANCE COMPANY FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, THESE POLICIES WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, SUBSCRIBERS ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY

CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF ANY QUALIFIED PROVIDER RENDERED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, FOR WHICH THE PROVIDER SUBMITTED A CLAIM WHICH WAS NOT ACCEPTED, THE CLAIM MAY BE RESUBMITTED. THE CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, THE CLAIM WILL BE PAID.

2. Commencing 30 days from the effective date of this order, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered at any time since January 1, 1976.

/s/ Peter F. Brady
PETER F. BRADY
Justice of the Superior Court

Entered: Oct. 17, 1980

APPENDIX D

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

SUFFOLK, ss:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff

v.

THE TRAVELERS INSURANCE COMPANY

—and—

METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

JUDGMENT ON FINDINGS BY THE COURT

This action came on for hearing before the Court, Brady, J., presiding, and the issues having been duly heard and findings having been duly rendered; it is ordered and adjudged as follows:

1. That the defendants are permanently enjoined from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976, or issued prior to January 1, 1976, but which have been altered or renewed through any change in premium or benefits.

This Judgment shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants has not provided the benefits required by

G.L. c. 175, § 47B at any time since January 1, 1976, the defendants shall, within 30 days of this Judgment provide to each such policyholder copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this Judgment. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHED MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE

JANUARY 1, 1976, FOR WHICH YOU DID NOT RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

The defendants further shall publish within 60 days in at least 3 mental health treatment journals of general circulation the following notice to providers of services who have made direct claims to the defendants, but who have not received reimbursement due to the defendant's noncompliance with G.L. c 175 § 47B:

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY ANY POLICIES ISSUED BY THE TRAVELERS INSURANCE COMPANY AND THE METROPOLITAN LIFE INSURANCE COMPANY FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, THESE POLICIES WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, SUBSCRIBERS ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHES MENTAL HEALTH SERV-

ICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976.

IF ANY QUALIFIED PROVIDER RENDERED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, FOR WHICH THE PROVIDER SUBMITTED A CLAIM WHICH WAS NOT ACCEPTED, THE CLAIM MAY BE RESUBMITTED. THE CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, THE CLAIM WILL BE PAID.

2. Commencing 30 days from the effective date of this order, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered at any time since January 1, 1976, on policies.

DATED AT BOSTON, MASSACHUSETTS, THIS 17TH DAY OF OCTOBER, 1980.

Form of Judgment Approved:

MICHAEL JOSEPH DONOVAN,
Clerk of Court

/s/ Peter F. Brady
Associate Justice of the Superior Court

By:
Assistant Clerk

APPENDIX E

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

SUFFOLK, ss:

Civil Action No. 35598

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff

v.

THE TRAVELERS INSURANCE COMPANY

—and—

METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

JUDGMENT ON FINDINGS BY THE COURT

This action came on for hearing before the Court, Brady, J., presiding, and the issues having been duly heard and findings having been duly rendered; it is ordered and adjudged as follows:

1. That the defendants are permanently enjoined from the failure to provide benefits for expense for treatment of mental and nervous conditions, as required by G.L. c. 175, § 47B, for residents of the Commonwealth who are subscribers of group insurance policies, issued by the defendants within or without the Commonwealth since January 1, 1976, or issued prior to January 1, 1976, but which have been altered or renewed through any change in premium or benefits.

This Judgment shall be implemented as follows:

1. Where a group insurance policy issued by either of the defendants has not provided the benefits required by G.L. c. 175, § 47B at any time since January 1, 1976, the defendants shall, on or before December 17, 1980, provide to each such policyholder (other than policyholders whom

the defendants previously provided with copies of the notice of benefit changes required by this Court's preliminary injunction entered August 28, 1979) copies of a notice of benefit changes, and shall provide that such notices be posted by the policyholder in a conspicuous manner and in a sufficient number of locations to provide notice to policy subscribers of the benefit changes implemented by this Judgment. Such notice shall contain the following language in at least 24 point type:

NOTICE OF BENEFIT FOR MASSACHUSETTS RESIDENTS

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY (NAME OF GROUP INSURANCE POLICY OR PLAN) FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, YOUR POLICY WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, YOU ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALTH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY CARE CENTER WHICH FURNISHED MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IN COVERAGE IS APPLICABLE TO ANY CLAIM FOR SUCH SERVICES PROVIDED SINCE (INSERT APPLICABLE EFFECTIVE DATE OF CHANGE).

IF YOU RECEIVED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE (INSERT APPLICABLE EFFECTIVE DATE OF CHANGE), FOR WHICH YOU DID NOT RECEIVE PAYMENT UNDER (NAME OF GROUP INSURANCE POLICY OR PLAN), YOU MAY FILE A CLAIM. YOUR CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, YOUR CLAIM WILL BE PAID.

The defendants further shall publish on or before Januuary 19, 1981 in at least 3 mental health treatment journals of general circulation the following notice to providers of services who have made direct claims to the defendants, but who have not received reimbursement due to the defendant's noncompliance with G.L. c. 175 § 47B:

IN ACCORDANCE WITH A FINAL JUDGMENT ENTERED BY THE SUPERIOR COURT OF MASSACHUSETTS, THE BENEFITS PROVIDED BY ANY POLICIES ISSUED BY THE TRAVELERS INSURANCE COMPANY AND THE METROPOLITAN LIFE INSURANCE COMPANY FOR MENTAL OR NERVOUS CONDITIONS HAVE BEEN CHANGED FOR MASSACHUSETTS RESIDENTS ONLY. IN ACCORDANCE WITH THE COURT'S ORDER, THESE POLICIES WILL PAY FOR INPATIENT AND OUTPATIENT SERVICES FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS, SUBJECT TO ANY APPLICABLE DEDUCTIBLE OR COINSURANCE PROVISIONS IN THE POLICY. IN THE CASE OF OUTPATIENT SERVICES, SUBSCRIBERS ARE COVERED TO THE EXTENT OF $500 PER YEAR FOR TREATMENT PROVIDED BY 1) A COMPREHENSIVE HEALH SERVICE ORGANIZATION; 2) A LICENSED HOSPITAL; 3) A LICENSED COMMUNITY MENTAL HEALTH CENTER, MENTAL HEALTH CLINIC OR DAY

CARE CENTER WHICH FURNISHES MENTAL HEALTH SERVICES; 4) A LICENSED PSYCHOLOGIST OR PSYCHIATRIST. THIS CHANGE IS APPLICABLE TO CLAIMS FOR SUCH SERVICES PROVIDED SINCE JANUARY 1, 1976. HOWEVER, THE EFFECTIVE DATE OF SUCH CHANGE WILL VARY FROM POLICY TO POLICY.

IF ANY QUALIFIED PROVIDER RENDERED TREATMENT FOR A MENTAL OR NERVOUS CONDITION SINCE JANUARY 1, 1976, AND AFTER THE EFFECTIVE DATE OF SUCH CHANGE, AND FOR WHICH THE PROVIDER SUBMITTED A CLAIM WHICH WAS NOT ACCEPTED, THE CLAIM MAY BE RESUBMITTED. THE CLAIM WILL BE EXAMINED AND IF THE BENEFIT CHANGES DESCRIBED IN THIS NOTICE APPLY, THE CLAIM WILL BE PAID.

2. Commencing December 18, 1980, the defendants shall pay expenses for benefits required by G.L. c. 175, § 47B on claims submitted by subscribers for services rendered (1) after the effective date of the policy, in the case of policies issued since January 1, 1976, and (2) after the effective date of the change of coverage, in the case of policies issued prior to January 1, 1976.

DATED AT BOSTON, MASSACHUSETTS, THIS 25TH DAY OF NOVEMBER, 1980.

Form of Judgment Approved:

MICHAEL JOSEPH DONOVAN,
Clerk of Court

/s/ Peter F. Brady, J.
Associate Justice of the Superior Court

By: /s/ Paul F. Mahoney
Assistant Clerk

APPENDIX F

COMMONWEALTH OF MASSACHUSETTS
SUPERIOR COURT

SUFFOLK, ss:

C.A. No. 35598

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff

v.

THE TRAVELERS INSURANCE COMPANY

AND

METROPOLITAN LIFE INSURANCE COMPANY,
Defendants

MEMORANDUM OF DECISION

This action came on to be heard before this court pursuant to the plaintiff Commonwealth of Massachusetts' motion for preliminary injunctive relief.

A review of the materials submitted by all the parties reveals the following pertinent information: The defendants are two major insurance companies, Metropolitan Life Insurance Company and The Travelers Insurance Company. As one part of their businesses, these companies sell group insurance policies which include coverage for hospital and surgical expenses. The group policies under consideration here were executed and sold to policyholders [1] outside the Commonwealth, but the insured

[1] The policyholders include corporations and unions which have established employee benefit programs in accordance with the requirements of ERISA, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

groups include individual subscribers who reside inside Massachusetts.

The Commonwealth urges that, since the groups include individual subscribers who reside in Massachusetts, the defendant insurers must provide, at least to the Massachusetts subscribers, coverage for expenses incurred for treatment of mental or nervous conditions, as required by G.L. c. 175, § 47B.[2] It is uncontested that the defendants do not provide these benefits, but they have suggested a number of reasons why they cannot be required to comply with G.L. c. 175, § 47B.

To compel compliance with this statute, the Commonwealth brought this action in which it seeks temporary and permanent injunctive relief, as well as a declaratory judgment. Only the Commonwealth's motion for a preliminary injunction is before this court at this time.

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[2] G.L. c. 175, § 47B provides, in relevant part, as follows:

> Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, . . . [shall] provide benefits for expense of residents of the Commonwealth covered under any such policy or plan, arising from mental or nervous conditions . . . which are at least equal to the following minimum requirement:
>
> . . . (c) In the case of outpatients benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a licensed or accredited hospital, (3) or subject to the approval of the department of mental health services furnished by a community mental health center . . . which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under provisions of chapter one hundred and twelve.

Whether this relief is sought under G.L. c. 175, § 3B [3] or under Mass. R. Civ. P. 65, the grant of such an order must be based upon findings both that the Commonwealth has demonstrated a strong likelihood of success on the merits of its claims that, if the requested injunction is not issued, irreparable harm will result to the Commonwealth outweighing any harm that defendants will suffer if the injunction is issued. *Lewis v. Richardson*, 428 F. Supp. 1164 (D. Mass. 1977); *Taunton Greyhound Association v. Town of Dighton*, Mass. Adv. Sh. (1977) 1521, 1526 n. 3; *Thayer Co. v. Binnall*, 326 Mass. 467, 475 (1950). The Commonwealth has successfully made both showings in this action.

Probability of Success of the Merits

In its brief, the defendant insurance companies advance three major arguments in support of their contention that they cannot be forced to comply with G.L. c. 175, § 47B. First, they argue that ERISA preempts the application of § 47B to the policies involved in the action. Second, they argue that the NLRA [4] also preempts § 47B. Finally, the defendants argue that the extraterritorial enforcement of § 47B would violate the Commerce Clause of the Constitution of the United States. The Commonwealth will in all probability, prevail on each of these points, and, as such, is likely to succeed on the merits of its case.

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[3] That statute authorizes the attorney general to seek injunctions to prevent violations of c. 175. Such injunctions may be issued upon two showings: "that a defendant is threatening or is likely to do any act or acts in violation of this chapter, and that such violation will cause irreparable injury to the interests of the people of the Commonwealth. . . ." Presumably, to obtain a preliminary injunction pursuant to § 3B, the attorney general must show a probability of success on the merits (that a defendant is or may violate the chapter) as well as show some irreparable harm that will occur without preliminary relief.

[4] National Labor Relations Act, 29 U.S.C. § 141 *et seq.*

Application of § 47B to the group insurance policies involved in this action is not precluded by ERISA's preemption provisions. Determining the scope of ERISA preemption involves a three-pronged analysis. Congress opted for a broad, general preemption provision, 29 U.S.C., § 1144(a). That section provides as follows:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall *supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

The insurance policies involved here are employee benefit plans within the meaning of 29 U.S.C. 1003(a), and are not within the exceptions contained in 29 U.S.C. § 1003 (b). Further, there is no question but that the Massachusetts statute, G.L. c. 175, § 47B relates to those plans. Thus, absent more, § 47B would be preempted by the broad language contained in § 1144(a).[5]

However, Congress did not stop with the broad preemption provision, and the second prong of analysis involves the "saving clause", § 1144(2)(A). That clause provides that:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

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[5] For a discussion of the fact that Congress opted for broad ERISA preemption, see *Hewlett-Packard Company v. Barnes*, 425 F. Supp. 1294, 1298-1300 (N.D. Cal. 1977), *aff'd* 571 F.2d 502 (9th Cir.), *cert. denied*, 99 S. Ct. 108 (1978). Innumerable other cases could be cited in support of this proposition. That Congress opted for a broad preemption provision is, however, not contested in this action.

G.L. c. 175, § 47B is a "law of any State which regulates insurance", and, would appear to be saved by the saving clause.

Finally, the saving clause is itself narrowed in the ERISA statutory scheme by the so-called deemer clause, § 1144(b)(2)(B), which provides:

> Neither an employee benefit plan described in section 1003(a) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Thus, as relevant to this case, a state may not deem an ERISA plan or trust established under such a plan to be an insurance company for the purpose of subjecting the plan or trust to state insurance law.

Read together, the three quoted provisions set out a scheme whereby a state may subject insurance companies that sell group policies to ERISA plans to state regulation, but may not so regulate ERISA plans that function as self-insurers. As such, the Commonwealth is likely to prevail on its contention that the group policies sold by the defendants that provide coverage for hospital and surgical expenses must include the coverage mandated by G.L. c. 175, § 47B, at least for the individual subscribers in the groups who reside in Massachusetts.

This same view was advanced by the First Circuit in *Wadsworth v. Whaland*, 562 F. 2d 70 (1st Cir. 1977), wherein a New Hampshire insurance law was upheld against an ERISA preemption argument. The New Hampshire statute was very similar to G.L. c. 175, § 47B, in that it, too, required that certain mental health benefits be contained in group policies sold outside New Hamp-

shire, but which included individual subscribers residing in that state.

> Thus, the deemer provision prevents a state from subjecting a plan, as a business of insurance, to the state's general insurance laws or enacting special legislation regulating plans as a "unique variety of insurance", *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294, 1300 (N.D. Cal. 1977) However, on its face the deemer provision does not prohibit a state from indirectly affecting plans by regulating the contents of group insurance policies purchased by the plans.

Wadsworth v. Whaland, 562 F. 2d at 77-78.

Defendants vigorously attack the rationale of this distinction, that is, the distinction between a state's power to regulate self-insuring plans and its power to regulate plans that operate through the purchase of insurance. See Hutchinson & Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 68-69 (1978). Defendants cite with approval the view of Messrs. Hutchinson & Ifshin that a more sensible reading of ERISA would permit a state to

> indirectly protect an insured employee benefit plan by regulating underwriting and reserve policies of the insurance carrier, even if such regulation affects the cost of the plan. On the other hand, a state should not be allowed to require that an ERISA plan provide a substantive benefit by enforcing an insurance regulation against the insurance carrier that provides the policy to the plan.

46 U. Chi. L. Rev. at 66-67. No support for this distinction is found in ERISA. Indeed, Congress reaffirmed the national policy embodied in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 et seq., favoring state regulation of the insurance industry, not only in ERISA's saving

clause, 29 U.S.C. § 1144(b)(2)(A), but also in § 1144 (d). The latter section provides, with exceptions not relevant here as follows:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law.

See also *Wadsworth*, 562 F. 2d at 78, n. 41. Absent a clear indication of Congressional intent to so sharply limit a state's power to regulate the insurance industry, it is probable that the trial court will adhere to the plain langauge of ERISA, thereby adopting the reasoning of the *Wadsworth* Court. If Congress finds that the adverse effect of the distinction outweighs the benefits of state regulation, it can certainly modify the statutory scheme.

Defendants second preemption argument is that, since many of the plans were the product of collective bargaining agreements, the National Labor Relations Act, 29 U.S.C. § 141 et seq., prohibits Massachusetts from imposing substantive provisions on the agreements. In view of the scope of ERISA premption, this argument is also likely to be rejected at the full hearing on the merits of this action.

The United States Supreme Court recently considered the scope of NLRA preemption in *Malone v. White Motor Corporation*, 435 U.S. 497 (1978). In upholding a Minnesota statute relating to pension funding against an NLRA preemption argument, the Court indicated that the key in such an inquiry is the intent of Congress, and that not all state legislation that relates to matters subject to compulsory bargaining under the NLRA is preempted.

> There is little doubt that under the federal statutes governing labor-management relations, an employer must bargain about wages, hours, and work-

> ing conditions and that pension benefits are proper subjects of compulsory bargaining. But there is nothing in the NLRA, including those sections on which appellee relies, which expressly forecloses all state regulatory power with respect to those issues, such as pension plans, that may be the subject of collective bargaining. If the Pension Act is preempted here, the congressional intent to do so must be *implied* from the relevant provisions of the labor statutes.

435 U.S. at 504-505. (emphasis in original). Thus, in *Malone*, the Court looked to the relevant provisions of labor law, especially the nonpreemption provisions in § 10 of the Welfare and Pension Plans Disclosure Act of 1958,[6] and reasoned that Minnesota was free to mandate certain pension funding, even though its statute directly contradicted a provision in a collective bargaining agreement.

The Welfare and Pension Plans Disclosure Act of 1974 was explicitly repealed by ERISA, 29 U.S.C. § 1031 (a)(1), and, in enacting ERISA Congress opted for broad preemption of state laws affecting ERISA plans. However, whether or not a particular state law, here G.L. c. 175, § 47B, has been preempted by ERISA, requires an inquiry into the intent of Congress. As discussed at great length earlier in this memorandum,[7] G.L. c. 175, § 47B, is not preempted by ERISA. Further, no other provision of federal law requires preemption of the Massachusetts statute, and the fact that the coverage of many of the plans was the subject of collective bargaining agreements, without more, is unlikely to convince the trial court that preemption is appropriate. See 435 U.S. at 504-505.

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[6] Originally codified at 29 U.S.C. § 301 *et seq.* ERISA did not become effective until after the relevant events in *Malone*, and, as such, the 1958 enactment was found by the Supreme Court to be controlling. 435 U.S. at 505-506, n.7.

[7] See pages 3-7.

Defendants next suggest that the Commerce Clause of the United States Constitution prohibits the Commonwealth from forcing them to comply with G.L. c. 175, § 47B. This argument is highly unlikely to persuade the trial court.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, provided the states with broad authority to regulate insurance free from Commerce Clause attacks. *Prudential Insurance Company v. Benjamin*, 328 U.S. 408, 429-433 (1946). The principal limitations on this power relate to due process considerations, *State Board of Insurance v. Todd Shipyards Corporation*, 370 U.S. 451, 453-456 (1962), and to situations in which Congress itself has enacted insurance legislation, 15 U.S.C. § 1012(b). The latter exception is inapplicable here in view of the preemption scheme embodied in ERISA. The former exception finds its roots in the legislative history of the McCarron-Ferguson Act. A good example is provided by the following language, quoted in the *State Board of Insurance* case, 370 U.S. at 455-456:

> "It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the Southeastern Underwriters Association case. Briefly, your committee is of the opinion that we should provide for the continued regulation and taxation of insurance by the States, subject always, however, to the limitations set out in the controlling decisions of the United States Supreme Court, as, for instance, in Allgeyer v. Louisiana (165 U.S. 578 [, 17 S.Ct. 427, 41 L. Ed. 832]), St. Louis Cotton Compress Co. v. Arkansas (260 U.S. 346[, 43 S.Ct. 125, 67 L.Ed. 297)], and Connecticut General [Life] Insurance Co. v. Johnson (303 U.S. 77, [, 58 S.Ct. 436, 82 L.Ed. 673)], which hold, inter alia, that a State does not have power to tax contracts of insur-

ance or reinsurance entered into outside its jurisdiction by individuals or corporations resident or domiciled therein covering risks within the State or to regulate such transactions in any way." H.R. Rep. No. 143, 79th Cong., 1st Sess., p. 3 U.S. Code Cong. Service 1945, p. 670.

In the three cases cited, the companies involved were found to have had too few contracts with the regulating state to justify the state action.

> . . . The Allgeyer case held that Louisiana by reason of the Due Process Clause of the Fourteenth Amendment could not make it a misdemeanor to effect insurance on Louisiana risks with an insurance company not licensed to do business in Louisiana, where the insured through use of the mails contracted in New York for the policy. The St. Louis Cotton Compress case held invalid under the Due Process Clause an Arkansas tax on the premiums paid for a policy on Arkansas risks, made with an out-of-state company having no office or agents in Arkansas. The Connecticut General Life Insurance case held invalid under the Due Process Clause a California tax on premiums paid in Connecticut by one insurance company to another for reinsurance of life insurance policies written in California on California residents, even though both insurance companies were authorized to do business in California. The Court stated:
>
> > "All that appellant did in effecting the reinsurance was done without the state and for its transaction no privilege or license by California was needful. The tax cannot be sustained either as laid on property, business done, or transactions carried on within the state, or as a tax on a privilege granted by the state." 303 U.S., at 82, 58 S.Ct. at 439.

By contrast, however, the defendants are likely to be found to have sufficient contacts with the Commonwealth of Massachusetts to justify the limited regulation imposed upon them by G.L. c. 175, § 47B. The defendant companies have been licensed to conduct insurance business in the Commonwealth for over one hundred years.[8] Both companies do an active business in Massachusetts and derive substantial income therefrom. Affidavit of Donald L. Becker at page 3. The group policies involved in this action include individual subscribers who reside inside the Commonwealth and to whom and/or for whom payments are made in Massachusetts. These contacts are likely to be found to be sufficient to justify the Commonwealth's enforcement of G.L. c. 175, § 47B, at least with respect to coverage for individual subscribers residing in Massachusetts.

Irreparable Harm

To obtain the preliminary relief requested, the Commonwealth must show that, in addition to a probability of success on the merits, irreparable harm will result to the interests of the people of the Commonwealth if the requested relief is not forthcoming, outweighing any harm that defendants will suffer if the injunction is not issued. *Lewis v. Richardson*, 428 F. Supp. 1164 (D. Mass. 1977); *Taunton Greyhound Racing Association v. Town of Dighton*, Mass. Adv. Sh. (1977) 1525, 1526 n. 3; *Thayer Company v. Binnall*, 326 Mass. 467, 475 (1950).

In support of its contention that irreparable harm has resulted and will continue to result from the failure of the defendants to comply with G.L. c. 175, § 47B, the

[8] Exhibits A and B to the Commonwealth's complaint indicate that the Travelers Insurance Company has been continually licensed to do business in the Commonwealth since July 23, 1864, (Exhibit A), and that Metropolitan Life Insurance Company has been so licensed since November 15, 1866, (Exhibit B). These exhibits may properly be considered by this court as evidence, G.L. c. 175 § 16.

Commonwealth alleges that "many residents of the Commonwealth have been deterred from obtaining treatment, or have been forced to discontinue treatment for mental and nervous conditions." Complaint ¶ 17.

Defendants vigorously assert that this alleged harm is too speculative to provide the foundation for a mandatory preliminary injunction. It is true that harm such as that suggested by the Commonwealth defies quantification. It does not follow, however, that the harm is not present or that it is not irreparable.

An individual's decision to seek help for mental or nervous disorders is undoubtedly a complex and multifaceted one. This court has no difficulty accepting the proposition, however, that the financial costs of such treatment is frequently an important factor in making this decision. This factor may either deter an individual from seeking or continuing help, or, it may convince one to curtail the amount of treatment sought. It is equally clear that the Commonwealth has a strong interest in the mental health of its citizens and that G.L. c. 175, § 47B, was enacted to alleviate the financial pressures associated with mental health care.

In support of its irreparable harm argument, the Commonwealth has offered the affidavit of Carolyn A. LaMarre, an employee of the Massachusetts Association for Mental Health (MAMH).[9] In her affidavit, Ms. LaMarre describes a survey of various mental health clinics conducted by her in the summer and fall of 1978. She concludes, in relevant part, in the following manner:

> 8. Clinics have responded to the failure of certain insurance companies to reimburse for the treatment in three different ways: (a) some clinics require

[9] Ms. LaMarre describes the organization, in part, as follows: "MAMH, formed in 1913, is a private non-profit citizens organization working for quality mental health care in Massachusetts." Affidavit of Carolyn A. LaMarre at p. 1.

> that clients with insurance coverage pay the full amount of the fee even though the company refuses to pay. . .; (b) some clinics put the client whose company refuses to pay on a sliding scale fee based on their ability to pay a portion of the total clinic for the clinical service; (c) some clinics totally absorb or write off the cost of service to clients whose companies refuse to pay.

Affidavit of Carolyn A. LaMarre at p. 3. At least with respect to category (a) and, to some extent, category (b), clients must make the choice between paying or limiting or eliminating treatment. Indeed some clients may not even have the financial luxury of making the choice, as they may be unable to pay the entire fee or the part the clinic requires them to pay based upon its sliding scale.

The mental health of its citizenry is of paramount concern to the Commonwealth. The response of the clinics to the actions of insurance companies such as defendants, further buttresses this court's conclusion that this mental health is being and will continue to be impaired by the refusal of defendants to comply with G.L. c. 175, § 47B. This is irreparable harm, and is more than sufficient to support the issuance of a preliminary injunction at this time.

Balanced against this harm is the severe financial loss defendants suggest they will suffer if they are forced to comply with G.L. c. 175, § 47B, should it turn out later that the statute is unenforceable against them. Defendants correctly point out that this situation is compounded by the fact that the Commonwealth cannot be required to post a bond as a precondition to the issuance of the injunction. G.L. c. 175, § 3B. However, it is unlikely that defendants will prevail on the merits, and it is possible that at least some of those additional costs can be recovered in later premium adjustment.

The court has compared the harm to the interests of the people of the Commonwealth that will result if a preliminary injunction is not issued with the financial loss that defendants will suffer if a preliminary injunction is issued. The scales weigh heavily in favor of issuing an injunction. The mental health of the people of the Commonwealth is too important to place in jeopardy particularly since, in all probability, the Commonwealth will succeed on the merits of its claim.

For the reasons set forth in this memorandum, it is hereby ordered that a preliminary injunction issue requiring that the defendants comply with the provisions of G.L. c. 175, § 47B. Plaintiff will be given ten days in which to propose to this court the precise terms of that injunction.

Entered: August 13, 1979

/s/ Joseph S. Mitchell, Jr.
JOSEPH S. MITCHELL, JR.
Justice of the Superior Court

APPENDIX G

SUPREME COURT OF THE UNITED STATES

No. A-1045

METROPOLITAN LIFE INSURANCE COMPANY and
TRAVELERS INSURANCE COMPANY,
Applicants

v.

MASSACHUSETTS

ORDER

UPON CONSIDERATION of the application of counsel for the applicants,

IT IS ORDERED that the time to docket an appeal and/or file a petition for a writ of certiorari in the above-entitled case be, and the same is hereby, extended to and including August 21, 1982.

/s/ William J. Brennan, Jr.
Associate Justice of the
Supreme Court of the
United States

Dated this 4th day of June, 1982.

APPENDIX H

ERISA

29 U.S.C. § 1001(b):

"It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."

29 U.S.C. § 1002:

"For the purposes of this subchapter:

"(1) The terms 'employees welfare benefit plan' and 'welfare plan' mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

• • •

"(3) The term 'employee benefit plan' or 'plan' means an employee welfare benefit plan or an em-

ployee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan."

29 U.S.C. § 1003(b)(3):

"(b) The provisions of this subchapter shall not apply to any employee benefit plan if—

• • •

"(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws . . . ."

29 U.S.C. § 1144:

"(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

"(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

"(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

"(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance

company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

"(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

"(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

"(c) For purposes of this section:

"(1) The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

"(2) The term 'State' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

"(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law."

Section 47B (Massachusetts G.L. c. 175 § 47B):

"Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and ten which provides hospital expense

and surgical expense insurance and which is issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth, during the period this provision is effective, or any policy of accident and sickness insurance as described in section one hundred and eight which provides hospital expense and surgical expense insurance and which is delivered or issued for delivery or subsequently renewed by agreement between the insurer and the policyholder in this commonwealth during the period that this provision is effective, or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is promulgated or renewed to any person or group of persons in this commonwealth while this provision is effective shall, provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions as described in the standard nomenclature of the American Psychiatric Association which are at least equal to the following minimum requirements:

"(a) In the case of benefits based upon confinement as an inpatient in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, the period of confinement for which benefits shall be payable shall be at least sixty days in any calendar year.

"(b) In the case of benefits based upon confinement as an inpatient in a licensed or accredited general hospital, such benefits shall be no different than for any other illness.

"(c) In the case of outpatient benefits, these shall cover, to the extent of five hundred dollars over a twelve-month period, services furnished (1) by a comprehensive health service organization, (2) by a

licensed or accredited hospital (3) or subject to the approval of the department of mental health services furnished by a community mental health center or other mental health clinic or day care center which furnishes mental health services or (4) consultations or diagnostic or treatment sessions, provided that such services under this clause are rendered by a psychotherapist or by a psychologist licensed under the provisions of chapter one hundred and twelve. For purposes of this clause 'psychotherapist' shall mean a person fully licensed to practice medicine under the provisions of chapter one hundred and twelve, who devotes a substantial portion of his time to the practice of psychiatry."

NLRA

29 U.S.C. § 151. Findings and declaration of policy

The denial by some employers of the right of employees to organize and the refusal by some employers to accept the procedure of collective bargaining lead to strikes and other forms of industrial strife or unrest, which have the intent or the necessary effect of burdening or obstructing commerce by (a) impairing the efficiency, safety, or operation of the instrumentalities of commerce; (b) occurring in the current of commerce; (c) materially affecting, restraining, or controlling the flow of raw materials or manufactured or processed goods from or into the channels of commerce, or the prices of such materials or goods in commerce; or (d) causing diminution of employment and wages in such volume as substantially to impair or disrupt the market for goods flowing from or into the channels of commerce.

The inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract, and employers who are organized in the corporate or other forms of

ownership association substantially burdens and affects the flow of commerce, and tends to aggravate recurrent business depressions, by depressing wage rates and the purchasing power of wage earners in industry and by preventing the stabilization of competitive wage rates and working conditions within and between industries.

Experience has proved that protection by law of the right of employees to organize and bargain collectively safeguards commerce from injury, impairment, or interruption, and promotes the flow of commerce by removing certain recognized sources of industrial strife and unrest, by encouraging practices fundamental to the friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions, and by restoring equality of bargaining power between employers and employees.

Experience has further demonstrated that certain practices by some labor organizations, their officers, and members have the intent or the necessary effect of burdening or obstructing commerce by preventing the free flow of goods in such commerce through strikes and other forms of industrial unrest or through concerted activities which impair the interest of the public in the free flow of such commerce. The elimination of such practices is a necessary condition to the assurance of the rights herein guaranteed.

It is declared to be the policy of the United States to eliminate the causes of certain substantial obstructions to the free flow of commerce and to mitigate and eliminate these obstructions when they have occurred by encouraging the practice and procedure of collective bargaining and by protecting the exercise by workers of full freedom of association, self-organ-

ization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection.

29 U.S.C. § 157. Right of employees as to organization, collective bargaining, etc.

Employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection, and shall also have the right to refrain from any or all of such activities except to the extent that such right may be affected by an agreement requiring membership in a labor organization as a condition of employment as authorized in section 158(a)(3) of this title.

29 U.S.C. § 158. Unfair labor practices

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(d) Obligation to bargain collectively

For the purposes of this section, to bargain collectively is the performance of the mutual obligation of the employer and the representative of the employees to meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment, or the negotiation of an agreement, or any question arising thereunder, and the execution of a written contract incorporating any agreement if requested by either party, but such obligation does not compel either party to agree to a proposal or require the making of a concession.

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McCARRAN-FERGUSON ACT

15 U.S.C. § 1012:

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1014:

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

APPENDIX I

IN THE SUPREME JUDICIAL COURT FOR THE
COMMONWEALTH OF MASSACHUSETTS
SUFFOLK COUNTY

SITTING, 1981

No. 2542

COMMONWEALTH OF MASSACHUSETTS,
Plaintiff-Appellee

v.

THE TRAVELERS INSURANCE COMPANY, and
METROPOLITAN LIFE INSURANCE COMPANY,
Defendants-Appellants

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that The Travelers Insurance Company and Metropolitan Life Insurance Company, defendants-appellants in this case, appeal to the Supreme Court of the United States from the final judgment entered in this action on March 24, 1982.

This appeal is taken pursuant to 28 U.S.C. 1257(2) and 2101.

Respectfully submitted,

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Dated: June 2, 1982